and C-Physical Therapist, 621 - Salaries-Aids and Orderlies, 622A, B, and C - Purchased Services of R.N.'s, L.P.N.'s and N.A.'s, 715 - Other Therapeutic Services, and other allowable salary and fees not specifically identified, excluding however 518 - Purchased Services and Repairs which will be included in e., All Other Expenses cost center; and excluding 415 - Medical Director, 711 - Physician Salaries/Fees, 751 - Recreational Activities Salaries and Social Worker Salaries which shall be reported in the OBRA-87 Expenses cost center. Costs will be allowed up to a ceiling maximum of the 80th percentile of the costs of all facilities arrayed.

d. **Energy Expenses:**

This cost center grouping will include allowable costs reported in Account No.'s 512 - Fuel, 513 - Gas, and 514 - Electricity. Costs will be allowed up to a ceiling maximum of the 75th percentile of the cost of all facilities arrayed.

e. **All Other Expenses:**

This cost center grouping will include all other allowable costs not specifically covered by grouping a, b, c d, f, and g and the line item A/C# 470 Health Care Provider Assessment. Costs will be allowed up to a ceiling maximum of the 80th percentile of the cost of all facilities arrayed.

f. **OBRA-87** This cost center grouping will include reasonable costs necessary to conform to the provisions of the Omnibus Budget Reconciliation Act of 1987

(OBRA-87), as reported in Accounts No. 415 - Medical Director, 711 - Physician Salaries/Fees, 713 - Social Worker Salaries/Fees, 751 - Recreational Activities Salaries, 1919(b)-1 Quality of Life, 1919(b)-2 Scope of Services and Activities Under Plan of Care, 1919(b)-3 Resident Assessment, 1919(b)-4 Provisions of Services and Activities, 1919(b)-5 Inservice Education/Training, 1919(b)-6 Physician Supervision and Clinical Records, 1919(b)-7 Social Services, 1919(c)-1 General Rights, 1919(c)-2 Transfer and Discharge Rights, 1919(c)-3 Access and Visitation Rights, 1919(c)-4 Equal Access to Quality Care, 1919(c)-5 Admission Policy, 1919(c)-6 Protection of Resident Funds, 1919(c)-7 Posting of Survey Results, 1919(d)-1 Administration, 1919(d)-2 Licensing and Life Safety Code, and 1919(d)-3 Sanitary and Infection Control and Physical Environment. Costs will be allowed up to a ceiling maximum of the 100th percentile of the cost of all facilities in the array.

g. **Management Related Expenses:**

This cost center grouping will include all allowable costs reported in Accounts No. 411-Administrator, 412 - Officers/Owners, 421 - Other Administrative Salaries, 431 - Health Care Plan (Employer's share-portion attributable to personnel included within this cost center), 432 - Other Employee Fringe Benefits (portion attributable to personnel included within this cost center), 433 - Home Office/Central Services (portion attributable to labor and payroll-related expenses), 435 - Computer Payroll/Data Processing Charges, 436 - Accounting/Auditing Fees, 437 - Legal Services, 440 - Payroll Taxes (portion

attributable to personnel included within this cost center), 442 - Insurance (Workers Compensation, group life, pension and retirement-portion attributable to personnel included within this cost center), 444A -Utilization Review Medicaid Title XIX,449A - Miscellaneous Labor & Payroll Related, 523 - Dietary Consultant, 712 - Pharmacists Salaries/Fee, Costs will be allowed up to a ceiling maximum of the 75th percentile of the costs of all facilities arrayed and effective September 1, 1996 cost will be allowed up to a ceiling maximum of the 80th percentile of the cost of all facilities.

and,

h. Each facility will report in Account #470 the expenditure for Health Care Provider Assessment. The costs in this line item attributable to program revenue received on or after June 1, 1992 will be fully recognized for reimbursement.

METHOD OF DETERMINING INDIVIDUAL PROSPECTIVE RATES

1. Each facility in operation during calendar year 1991 shall have its base year established in accordance with 'Appendix A' Audit Scheduling for all cost centers described in a., b., c., d. e. f. and g. above. Any facility commencing operation subsequent to calendar year 1991, shall have its first six months of operation as its base period.

2. Effective July 1, 1993, each facility will be assigned interim prospective rates utilizing the facility's base year BM-64 cost report adjusted by the percentage change in

the National Nursing Home Input Price Index recognized by the Rate Setting Unit of the Department of Human Services for rate years subsequent to the audited year up to and including rate year 1993,year,and in lieu of the application of the percentage increase for the rate year July 1, 1996 through June 30 1997 there shall be an additional price index adjustment of nine-tenths of one percent (.9%) effective July 1, 1999 and subject to cost center maximums described in a., b., c., d., e, f. and g. above. The interim prospective per diem rate will be adjusted, if necessary, through results of an audit of base year costs.

3. An additional interim per diem rate will be calculated and added to each nursing facility rate to recognize reimbursement for expenditure in account #470 Health Care Provider Assessment for Rhode Island Medical Assistance Program revenue.

4. Starting with the reporting year 1991 and with every reporting year thereafter, one-third of the participating facilities will have a new base year. The prospective rate of each facility with a new base year will be recalculated after the completion of an audit and will be effective July 1 of the year subsequent to the year in which the audit was scheduled. The recalculated rate will reflect the actual allowable costs as determined by the audit updated by the National Nursing Home Input Price Index percentage increase(s) for the year(s) subsequent to the audited year,and in lieu of the application of the percentage increase for the rate year July 1, 1996 through June 30 1997 there shall be an additional price index adjustment of nine-tenths of one percent (.9%) effective July 1, 1999, to produce the prospective rate; provided, however, that the new prospective rate does not exceed the maximum rates established for each cost center ceiling.

5. Commencing with the State fiscal year beginning July 1, 1994 and each State fiscal year thereafter, excluding however the rate year July 1, 1996 through June 30, 1997, the annual percentage increase will be applied to all cost centers excluding the $18.97 and the $15.00 ceiling maximums identified in paragraph b. above entitled "Other Property Related Expenses" to determine new cost center ceilings. Commencing July 1, 1994, excluding however the rate year July 1, 1996 through June 30, 1997, individual facility cost center rates, excluding the cost center rate for Other Property Related Expenses Cost Center, will be adjusted annually by the amount of percentage change in the National Nursing Home Input Price Index for the 12-month period ending the previous March. The amount of percentage change to be utilized will be the index as projected by the Health Care Financing Administration on the first date it is available in the month of May of each year. Although the index may be obtained initially by telephone, it will be confirmed in writing.

6. Each nursing facility duly licensed and participating as of June, 1999, in lieu of the application of the percentage adjustment for the rate year July 1, 1996 through June 30, 1997, shall be paid a one-time supplemental medicaid participating incentive factor of three dollars and twenty-one cents ($3.21) per day for each medicaid patient day in calendar year 1997 as reported on the facility's BM-64 cost report for calendar year 1997.

APPEAL REQUESTS FOR RATE INCREMENTS

In those cases in which the assigned prospective rate of a facility falls below the new aggregate ceiling maximum, the Department of Human Services can consider the granting of a prospective rate that reflects demonstrated cost increases in excess of the rate that has been established by the application of the percentage increase. In order to qualify for such a rate increment, demonstrated increased costs must be a result from:

a. Demonstrated errors made during the rate determination process,

b. Significant increases in operating costs resulting from the implementation of new or additional programs, services or staff specifically mandated by the Rhode Island Department of Health,

c. Significant increases in operating costs resulting from capital renovations, expansion, or replacement required for compliance with Fire Safety Codes and/or Certification requirements of the Rhode Island Department of Health, or,

d. Significant increases in Workers Compensation and/or Health Insurance premiums which cannot be accommodated within the facility's assigned aggregate per diem rate will be allowed a rate increment, if cost justified, so long as the new assigned per

diem rates in the Labor Related Expenses cost center and in the Management Related Expenses cost center do not exceed two-percent (2%) of said cost center ceilings, or,

e. Extraordinary circumstances, including, but not limited to, acts of God, and inordinate increases in energy costs (e.g., federal BTU tax, regional or national energy crisis). Inordinate increases in energy costs will be immediately reflected in increased rates above the energy cost center ceiling maximum. Provided, however, that such increases will be rescinded immediately upon cessation of the extraordinary circumstance.

Initial requests for prospective rate adjustments in excess of those that would be established through application of established percentage increase, will first be reviewed by the Nursing Facility Rate Setting Unit within the Division of Medical Services within the Department of Human Services. This Unit will be empowered to grant such variances, provided that the facility involved meets the above criteria and provides all the necessary data.

Requests for rate increments will be limited to one request per annum per facility for the factors specified in items (b) (c) and (d) above. However, additional requests involving a recurring per diem increase in excess of one percent of the facility's previously assigned aggregate per diem rate will also be reviewed. Before a facility files for a rate increment, increases in operating costs addressed in (b) (c) and (d) above must have been incurred

for at least a three-month period in order to establish proof of such increase.

All costs, including salaries, must be absorbed within these group ceilings. The total ceiling maximum will be the sum total of the seven cost center ceilings. Commencing with fiscal year 1994, and all fiscal years thereafter, all participating providers that had an overall Medicaid occupancy rate in the preceding calendar year of 80 percent or greater will be allowed a .75 cent participating incentive factor per Medicaid patient day to encourage facilities to accept and serve Medicaid patients. All participating providers that had an overall Medicaid occupancy rate in the preceding calendar year of 50 percent or greater but less than 80 percent will be allowed a .35 cent participating incentive factor per Medicaid patient day. This participating incentive factor is subject to the ceiling maximum.

f. In addition to the above appeal requests, a facility may qualify for a rate increment adjustment, as determined by the department, in accordance with this subsection:

(a) The facility is located in a federally designated Enterprise Community; and

(b) The facility is incurring allowable costs in one or more cost centers in excess of the allowable maximum for such cost center(s); and

(c) The facility files a written request for a rate increment with the department which must include the following documentation:

i. A cost containment and revenue enhancement plan; and

ii. A cost report for the most recently completed six (6) months of

operations; and

iii. Such other documents as may be requested by the department.

The department shall review the written request and may grant a rate increment adjustment to become effective not earlier than the month the request was filed which:

1. may result in a per diem rate which shall not exceed the aggregate of all cost center maximums, plus the per diem rate to recognize reimbursement for the health care provider assessment in account #470; and

2. will be limited for a period not to exceed twenty-four (24) consecutive months; and the facility may reapply for a rate increment adjustment under this subsection for a period of twenty-four (24) consecutive months following the month of expiration or termination of an approved rate increment adjustment; and

3. subject to the aggregate limit in (1) above, may recognize reasonable and necessary costs incurred by the facility to achieve the cost containment/revenue enhancement plan approved by the department; and

4. will be established for an initial six (6) month period, and may be extended and adjusted by the department for an additional six (6) month periods (but not to exceed the overall maximum twenty-four (24) month limit); and

5. will be subject to continuing review and monitoring by the department and such terms and conditions to be specified by the department in a rate

increment approval letter (for initial and extended periods) to the facility.

Rate adjustments granted as a result of a request filed within 120 days after the costs were first incurred will be made effective retroactively to the date such costs were incurred. However, any adjustments granted as a result of requests filed beyond 120 days after the costs were first incurred will be effective on the first day of the month following the filing of the request.

PAYMENTS

The State of Rhode Island reimburses a provider monthly for Medicaid patient days time the assigned prospective per diem rate.

The State of Rhode Island reserves the right to investigate and adjust reimbursement rates for facilities which do not substantially comply with all standards of licensure.

In determining the number of days for which payment may be made the date of admission is counted, however the date of death or discharge is not counted.

The per diem rate for eligible Title XIX recipients is a full payment rate and, therefore, under State General Law Section 40-8.2-3 and Federal regulations, subsidy for patient care by either the patient, relatives or friends to the facility in any manner is